Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Summary of Proposed Rule

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I. Introduction and Background

On April 27, 2018, the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed rule updating the Medicare hospice payment rates, wage index, and the quality reporting requirements for fiscal year (FY) 2019. Page references given in this summary are to the display copy. The proposed rule will be published in the May 8, 2018 issue of the *Federal Register.* **Comments on the proposed rule are due by June 26, 2018.**

CMS estimates that the overall impact of the proposed rule will be an increase of $340 million (1.8 percent) in Medicare payments to hospices during FY 2019.

This proposed rule describes current trends in hospice utilization and provider behavior as well as CMS efforts for monitoring potential impact. CMS proposes regulatory changes expanding the definition of attending physicians for Medicare hospice beneficiaries to include physician assistants (PA). Effective January 1, 2019, Medicare will pay services provided by PAs to Medicare beneficiaries who elect the hospice benefit and select a PA as their attending physician.[1] With respect to the Hospice Quality Reporting Program (HQRP), CMS proposes an eighth factor to consider when evaluating measures for removal from the HQRP measure set: the costs associated with a measure outweigh the benefit of its continued use in the program. CMS proposes to add on the Hospice Compare website the HIS-based Hospice Comprehensive Assessment Measure (NQF #3235) and Hospice Visits When Death Is Imminent Measure Pair.

[1] Section 51006 of the Bipartisan Budget Act of 2018 amended section 1861(dd)(3)(B) of the Social Security Act to include PAs as attending physicians.

CMS is also requesting suggestions for consideration in the Conditions of Participation related to ways to better achieve interoperability or to improve the sharing of healthcare data between providers.

CMS notes that wage index addenda will be available only through the internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html

The proposed rule discusses its Meaningful Measures Initiative and Advancing Health Information Exchange,[2]reviews the history of the Medicare hospice benefit, including hospice reform policies finalized in the FY 2016 hospice final rule (80 FR 47142); this rule, among other things, differentiated payments for routine home care (RHC) based on the beneficiary's length of stay and implemented a service intensity add-on (SIA) payment for services provided in the last 7 days of a beneficiary's life. CMS notes that the number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to nearly 1.5 million in FY 2017. Similarly, Medicare hospice expenditures have risen from $2.8 billion in FY 2000 to an estimated $17.5 billion in FY 2017. Over one-quarter of the hospice claims in FY 2017 had one of these principal diagnoses: Alzheimer's disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Senile Degeneration of Brain, and Lung Cancer.

II. Provisions of the Proposed Rule

A. Monitoring for Potential Impacts-Affordable Care Act Hospice Reform

1. Hospice Payment Reform: Research and Analyses

This section of the proposed rule describes current trends in hospice utilization and provider behavior including lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending. CMS also includes preliminary information from FY 2016 on the costs of hospice care using data from the revised hospice Medicare cost report.

Length of Stay

The number of days that a hospice beneficiary receives care under a hospice election is referred to as the hospice length of stay. The hospice length of stay is variable and depends on a multitude of factors including disease course, timing of referral, decision to resume curative treatment, and/or stabilization or improvement where the individual is no longer certified as terminally ill. CMS examined length of stay during a single hospice election and total lifetime length of stay – the sum of all days of hospice care across all hospice elections.

[2] CMS launched the Meaningful Measures Initiative in October 2017 with the intent to reduce the regulatory burden on the health care industry, lower health care costs, and enhance patient care. As part of this effort, CMS identified 19 Meaningful Measure areas and mapped them to six overarching quality priorities. With respect to the Advancing Health Information Exchange, CMS discussed a number of initiatives the Department of Health and Human Services has to encourage and support the adoption of interoperable health information technology.

In FY 2017, the average length of stay in hospice was 79.7 days and average lifetime length of stay in hospice was 96.2 days, virtually unchanged from prior year. The median (50th percentile) length of stay was 18 days. CMS also examined average lifetime length of stays associated with hospice principal diagnosis by site of service at admission in FY 2017 for those receiving RHC. Among the four levels of hospice care, RHC accounts for 98 percent of all hospice days. See Table 3 in the proposed rule (page 23 of the display copy). Hospice beneficiaries with a primary diagnosis of Alzheimer's, Dementia, and Parkinson's had the longest average lifetime length of stay at 177 days and Chronic Kidney Disease had the shortest average length of stay at 57 days.

Live Discharge Rates

CMS also notes that starting July 1, 2012, the discharge information collected on the Medicare hospice claim was expanded to capture the reason for all types of discharges. To better understand the characteristics of hospices with high live discharge rates, CMS examined hospice live discharge rates over time, the discharge rates among hospices with 50 or more discharges, and by length of stay.[3] Overall, CMS found that between 2007 and 2017, the overall rate of live discharges has decreased from 21.9 percent in 2007 to 16.7 percent in 2017. There is significant variation in the rate of live discharge between the 10th and 90th percentile (as shown in Table 6, pages 28 of the display copy). The median live discharge rate is around 17 percent but hospices at the 95th percentile discharged 47.6 percent of their patients alive in FY 2017. CMS also indicates that the proportion of live discharges occurring between length of stay intervals has remained relatively constant from FY 2013 to FY 2017.

CMS notes that overall its analyses do not reveal any anomalies in trends in length of stay and rates of live discharge at this time, but that it will continue to monitoring the available data.

Skilled Visits in the Last Days of Life

CMS notes that it remains concerned that many beneficiaries are not receiving skilled visits during the last few days of life. Their analysis of 2017 claims data shows that on any given day during the last 7 days of a hospice election, nearly 42 percent of the time the patient had not received a skilled visit (skilled nursing or social worker visit), a slight improvement from 44 percent for this metric using 2016 claims data. Tables 7, 8, and 9 in the proposed rule (pages 31-33 of the display copy) show the frequency and length for skilled nursing and social work combined, skilled nursing only, and social work only. CMS also examined the overall levels of nursing and medical social services provided during the 7 days prior to death and found that the RHC level of care for this period was approximately 1.6 hours per day – over three quarters of the hours were provided by registered nurses (RNs). CMS states it is concerned about the lack of increase in visits to hospice patients at the end of life as beneficiaries appear to be receiving similar levels of care even after payment policy reforms were implemented to address this issue. Specifically, the SIA payment was intended to compensate providers for the cost of providing additional, more intensive care at the end of life. CMS states it will continue to monitor the provision of services at end-of-life and impacts of the SIA payment and other policies.

[3] CMS doesn't expect the rate of live discharges to be zero, given the uncertainties of prognostication and the ability of beneficiaries and their families to revoke the hospice election at any time. CMS wants to ensure, however, that hospices are not discharging patients at their discretion to avoid costly on inconvenient care.

Non-hospice spending

CMS also provides data regarding non-hospice spending for hospice beneficiaries during an election using FY 2017 data. CMS emphasizes that hospice services are intended to be comprehensive and inclusive and that since the creation of this benefit, CMS has reiterated that "virtually all" care needed by the terminally ill individual should be provided by hospice, given the interrelatedness of body systems. Their analyses, however, suggest unbundling of services that should have been provided and covered under the Medicare hospice benefit may be occurring.

In FY 2017, the agency found that Medicare paid $566 million for Part A and Part B items or services while a beneficiary was receiving hospice care. Notably, non-hospice spending has been trending downward: down 23 percent from FY 2011 to FY 2017. In addition, total drug spending by Medicare, states, beneficiaries, and other payers in FY 2016 under Part D was $474.2 million for hospice beneficiaries during a hospice election (of which $380 million was paid by Medicare). Thus, in FY 2017, non-hospice Medicare expenditures occurring during a hospice election were $566 million for Parts A and B spending, plus $380 million for Part D spending, or about $946 million. Further, hospice beneficiaries had $138 million in cost-sharing for items and services that were billed to Medicare Parts A and B, and $68.6 million in cost-sharing for drugs that were billed to Medicare Part D, while they were in a hospice election.

CMS continues to be concerned based on its own analyses and those by the Office of the Inspector General that Medicare could be paying twice for drugs that are already covered under the hospice per diem payment by also paying for them under Part D.[4] CMS encourages hospices to educate beneficiaries regarding the comprehensive nature of the hospice benefit and inform beneficiaries if conditions are identified by the hospice as unrelated to the terminal illness and related conditions; this should occur at or near the time of the election and the clinical rationale should be provided. CMS notes its intent to continue to monitor this issue and will consider ways to address this issue through regulatory and/or program integrity efforts.

2. Initial Analysis of Revised Hospice Cost Report Data

CMS made revisions to its hospice cost report form for freestanding hospices that become effective for cost reporting period beginning on or after October 1, 2014. Using information from this new cost report data for FY 2016 (2,867 reports), CMS compared the reported costs on the Medicare costs report to the FY 2016 per diem payment rates by level of care. CMS reports values using three district trimming methodologies intended to "trim" out implausible cost reports or cost reports that included unexpected data values (details on how CMS applied these trims in on pages 42-46 of the display copy). The first trim applies a simple truncation at the statistical ends of the data, the second trim is more robust – referred to as the "CMS Trim" –with more explicit criteria designed to remove aberrant data, and the third trim would apply industry-requested edits, referred to as "Level 1" edits. CMS notes that given the high volume of cost reports that show zero costs on lines its expects to be populated, nearly two-thirds of the cost reports would be rejected by MACs based on applying the Level 1 edits to the 2016 cost reports.

[4] https://oig.hhs.gov/oas/reports/region6/61000059.asp, ''Medicare Could Be Paying Twice for Prescriptions for Beneficiaries in Hospice.''

CMS emphasizes that these edits are for consideration only and have not yet been proposed and that it will continue to collaborate with the provider community to improve the quality of the hospice cost report data.

Table 12 in proposed rule (page 47 of display copy) shows the total cost per diem by level of care applying the three trim methodologies. For the provision of routine home care (98 percent of hospice days), the weighted mean and median cost per days were both lower than the per diem rate regardless of the trim approach applied. For all other levels of care (2 percent of hospice days), the cost values were higher than the per diem rate. CMS states that as it gathers more cost report data, it plans to conduct a more thorough analysis of the cost report data including a comparison of costs to payments. It continues to encourage hospices to submit accurate data.

B. FY 2019 Hospice Wage Index and Rates Update

A summary of key data for the proposed hospice payment rates for FY 2019 is presented below with additional details in the subsequent sections.

Summary of Key Data for Proposed Hospice Payment Rates for FY 2019			
Market basket update factor			
Market basket increase			+2.9%
Required multi-factor productivity (MFP) adjustment			-0.8%
ACA mandated reduction			-0.3%
Net MFP-adjusted update reporting quality data			**+1.8%**
Net MFP-adjusted update not reporting quality data			**-0.2%**
Hospice aggregate cap amount			$29,205.44
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2018 Federal Rates Per Diem**	**Proposed FY 20179 Federal Rates Per Diem**
Routine Home Care (days 1-60)	68.71%	$192.78	$196.25
Routine Home Care (days 61+)	68.71%	$151.41	$154.21
Continuous Home Care, Full Rate = 24 hours of care, $41.62 hourly rate	68.71%	$976.42	$998.77
Inpatient Respite Care	54.13%	$172.78	$176.01
General Inpatient Care	64.01%	$743.55	$758.07
Proposed Service Intensity Add-on (SIA) payment, up to 4 hours			$41.62 per hour

1. FY 2019 Hospice Wage Index

For FY 2019, CMS proposes to use the FY 2018 pre-floor, pre-reclassified hospital wage index to derive the applicable wage index values for the hospice program, and to continue its policy of not taking into account geographic reclassifications under the inpatient prospective payment system in determining payments for hospices.[5] CMS also proposes to continue to apply current

[5] The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC; based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

policies for handling geographic areas where there are no hospitals. For urban areas of this kind, all of the core-based statistical areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value for use as a reasonable proxy for these areas. In FY 2019, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia. For rural areas without hospital wage data, CMS has used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. However, the only rural area currently without a hospital is on the island of Puerto Rico, which does not lend itself to this "contiguous" approach. Because CMS has not identified an alternative methodology, the agency proposes to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

In the FY 2016 Hospice Wage Index final rule, CMS adopted the OMB's new area delineations (as described in the February 28, 2013 OMB Bulletin No. 13-01) and was fully transitioned beginning October 1, 2016. The proposed hospice wage index for FY 2019 would be effective October 1, 2018 through September 30, 2019.[6]

2. Proposed Hospice Payment Update Percentage

For FY 2019, the estimated inpatient hospital market basket update of 2.9 percent (the inpatient hospital market basket is used in determining the hospice update factor) must be reduced by a productivity adjustment as mandated by the ACA (currently estimated to be 0.8 percentage point) and further reduced by 0.3 percentage point as also mandated by the ACA. This results in a proposed hospice payment update percentage for FY 2019 of 1.8 percent; CMS proposes to revise this amount in the final rule if more recent data become available.

CMS notes that the labor portion of the hospice payment rates is currently as follows: for Routine Home Care, 68.71 percent; for Continuous Home Care, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent.

3. Proposed FY 2019 Hospice Payment Rates

In the hospice payment system, there are four payment categories that are distinguished by the location and intensity of the services provided: RHC or routine home care, IRC or short-term care to allow the usual caregiver to rest, CHC or care provided in a period of patient crisis to maintain the patient at home, and GIP or general inpatient care to treat symptoms that cannot be managed in another setting. The applicable base payment is then adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index.[7]

In FY 2016 Hospice final rule, CMS made several modifications to the hospice payment methodology. CMS implemented two different RHC payment rates: one for the RHC rate for

[6] The proposed wage index applicable for FY 2019 is available on the CMS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.

[7] In FY 2014 and for subsequent fiscal years, CMS uses rulemaking as the means to update payment rates (prior to FY 2014, CMS had used a separate administrative instruction), consistent with the rate update process for other Medicare payment systems.

the first 60 days and a second RHC rate for days 61 and beyond. CMS also adopted a Service Intensity Add-on (SIA) payment when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provider (up to 4 hours total) that occurred on the day of the service. As required by statute, the new RHC rates were adjusted by a SIA budget neutrality factor. For FY 2019, the budget neutrality factor for days 1 through 60 is 0.9991, and for days 61 and beyond the factor is 0.9998.[8]

In the FY 2017 Hospice final rule, CMS initiated a policy to apply a wage index standardization factor to hospice payment rates in order to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data. CMS uses the same approach in other payment settings such as under Home Health Prospective Payment System (PPS), IRF PPS, and SNF PPS. To calculate the wage index standardization factor, CMS simulated total payments using the FY 2019 hospice wage index and compared it to its simulation of total payments using the FY 2018 hospice wage index. By dividing payments for each level of care using the FY 2019 wage index by payments for each level of care using the FY 2018 wage index, CMS obtained a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP).

Lastly, the RHC rates would be increased by the proposed FY 2019 hospice payment update percentage of 1.8 percent, adjusted by the SIA budget neutrality factor, and the proposed wage index standardization factor. The proposed FY 2019 payment rates for CHC, IRC, and GIP would be the FY 2018 payment rates increased by 1.8 percent and adjusted by the proposed wage index standardization factor.

Tables 13 and 14 of the proposed rule (reproduced below) list the preliminary FY 2019 hospice payment rates by care category as well as the proposed SIA budget neutrality factors and the proposed wage index standardization factors.

Table 13: Proposed FY 2019 Hospice RHC Payment Rates

Code	Description	FY 2018 Payment Rates	Proposed SIA budget neutrality factor adjustment	Proposed Wage Index Standardization Factor	Proposed FY 2019 hospice payment update	Proposed FY 2019 Payment Rates
651	Routine Home Care (days 1-60)	$192.78	x 0.9991	x 1.0009	x 1.018	$196.25
651	Routine Home Care (days 61+)	$151.41	x 0.9998	x 1.0007	x 1.018	$154.21

[8] The budget neutrality adjustment calculation that would apply to days 1 through 60 is equal to 1 minus the ratio of SIA payments for days 1 through 60 to the total payments. Similarly, the budget neutrality adjustment for days 61 and beyond is equal to 1 minus the ratio of SIA payments for days 61 and beyond to the total payments for days 61 and beyond.

Table 14: Proposed FY 2019 Hospice Payment Rates for CHC, IRC, and GIP

Code	Description	FY 2018 Payment Rate	Proposed Wage Index Standardization Factor	FY 2019 Proposed Hospice Payment Update	FY 2019 Proposed Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care, $41.62 hourly rate	$976.42	x 1.0048	x 1.018	$998.77
655	Inpatient Respite Care	$172.78	x 1.0007	x 1.018	$176.01
656	General Inpatient Care	$743.55	x 1.0015	x 1.018	$758.07

Tables 15 and 16 of the proposed rule (pages 59-60 of the display copy) list the comparable FY 2019 preliminary payment rates for hospices that do not submit the required quality data under the Hospice Quality Reporting Program as follows: Routine Home Care (days 1-60), $192.39; Routine Home Care (days 61+), $151.18; Continuous Home Care, $979.14; Inpatient Respite Care, $172.56; and General Inpatient Care, $743.18.

4. Hospice Cap Amount for FY 2019

By way of background, when the Medicare hospice benefit was implemented, Congress included 2 limits on payments to hospices: an aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end-of-life, and the intent of the inpatient cap was to ensure that hospice remained a home-based benefit.[9] The aggregate cap amount was set at $6,500 per beneficiary when first enacted in 1983, and since then this amount has been adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI-U).

As required by the Impact Act, beginning with the 2016 cap year, the cap amount for the previous year will be updated by the hospice payment update percentage, rather than by the CPI-U for medical care. This provision will sunset for cap years ending after September 30, 2025, and revert back to the original methodology. CMS adds that the proposed hospice aggregate cap amount for the 2019 cap year will be $29,205.44 per beneficiary or the 2018 cap amount updated by the FY 2019 hospice payment update percentage ($28,689.04 * 1.018).

CMS also proposes to make a technical correction in §418.3 to reflect the revised timeframes for the hospice cap period that was finalized in the 2016 Hospice Final Rule. The cap year now aligns with the federal fiscal year, beginning October 1 and ending September 30. CMS proposes that the cap period would mean the twelve-month period ending September 30 used in the application of the cap on overall hospice reimbursement.

[9] If a hospice's inpatient days (GIP and respite) exceed 20 percent of all hospice days, then for inpatient care the hospice is paid: (1) the sum of the total reimbursement for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to actual number of all inpatient days; and (2) the sum of the actual number of inpatient days in excess of the limitation by the routine home care rate.

C. Request for Information Update – Comments Related to Hospice Claims Processing

In the FY 2018 Hospice proposed rule, CMS invited comments about improvements that could be made to reduce unnecessary burdens for clinicians, other providers, and patients and their families.

Commenters suggested that CMS remove the requirement to report detailed drug data on the hospice claim. CMS evaluated this requirement and determined that this information is not currently used for quality, payment or program integrity purposes and proposes to remove this requirement effective October 1, 2018. CMS will allow hospices two options for reporting hospice drug information. Providers will have the option to continue to report infusion pumps and drugs, with corresponding NDC information, on the hospice claim as separate line items; this option will no longer be mandatory. Alternatively, hospices can submit total, aggregate DME and drug charges on the claim. CMS will issue a sub-regulatory change request that will be effective October 1, 2018.

CMS discusses suggestions to remove the sequential billing requirement, which requires claims to be submitted in chronological order. CMS explains that sequential billing is required because the statute defines hospice benefit periods as two benefit periods of 90 days each and an unlimited number of subsequent periods of 60 days each. Sequential billing ensures that the Medicare systems create and exhaust each period before creating a later period. In addition, payment for routine care varies depending on length of stay, making sequential billing necessary to accurately pay claims.

D. Proposed Regulations Text Changes Recognizing Physician Assistants as Designated Attending Physician

When electing the hospice benefit, a Medicare beneficiary agrees to forego the right to have Medicare payment made for services related to their terminal illness and related condition, except when services are provided b the designated hospice and the beneficiary's designated attending physician (1812(d)(2)(A) of the Act). The designated physician is required to certify that the beneficiary is terminally ill and participate as a member of the hospice interdisciplinary group (IDG) that establishes and updates the individual's plan of care. Under the current hospice regulations, the attending physician is defined as a doctor of medicine or osteopathy, or a nurse practitioner and is identified by the individual as having the most significant role in the determination and delivery of the beneficiary's medical care. The attending physician must be legally authorized to perform services in the state in which the services are performed.

Section 51006 of the Bipartisan Budget Act (BBA) (Pub. L.115-123) amended the Act such that effective January 1, 2019, physician assistants (PAs) will also be recognized as designated hospice attending physicians.[10] CMS notes that PAs are authorized to furnish services under their State scope of practice and under the general supervision of a physician (section 1861(s)(2)(K)(i) of the Act). Therefore, payments for PA services are made to the employer or a contractor of a PA.

[10] The PA qualifications for eligibility for furnishing services under Medicare can be found in the regulations at 42 CFR 410.74(c).

Effective January 1, 2019, Medicare will pay for medically reasonable and necessary services provided by PAs to Medicare beneficiaries who elect the hospice benefit and select a PA as their attending physicians. PAs are paid 85 percent of the fee schedule amount for their services as the designated physicians. The services provided by PAs may be separately billed to Medicare only if the PA is the beneficiary's designated attending physician; services are medically reasonable and necessary; services would normally be performed by a physician; and the services are not related to the certification of the terminal illness. The PA does not need to be directly employed by the hospice.

Because PAs are not physicians (as defined in 1861(r)(1) of the Act), they may not act as a hospice medical director or certify the beneficiary's terminal illness. In addition, hospices may not contract with a PA for their attending physician services as described in section 1861(dd)(2)(B)(i)(III) of the Act, which outlines the requirements of the interdisciplinary group as including at least one physician, employed by or under contract with the hospice. These provisions apply to PAs whether or not they are employed by the hospice. In addition, the BBA of 2018 did not make any changes to which practitioners can certify the terminal illness for a Medicare beneficiary nor who may perform the face-to-face encounter. Only a medical doctor or a doctor of osteopathy can certify or re-certify the terminal illness. Only a hospice physician or a hospice nurse practitioner can perform the hospice face-to-face encounter.

E. Updates to the Hospice Quality Reporting Program (HQRP)

The Hospice Quality Reporting Program (HQRP) includes the Hospice Item Set (HIS) and the Consumer Assessment of Healthcare Providers and System (CAHPS). Section 1814(i)(5)(A)(i) of the Act requires that beginning in FY 2014, hospices that fail to meet quality data submission requirements will receive a two percentage point reduction to the market basket update. Any measure selected by the Secretary must have been endorsed by the consensus-based entity holding a contract for performance measures (currently held by the National Quality Forum (NQF)). However, the Secretary may specify measures that are not so endorsed as long as a feasible and practical measure has not yet been endorsed by the consensus-based entity and consideration is given to measures that have been endorsed by the consensus-based organization.

CMS discusses the various social risk factors that may affect measures in the HQRP. The first report by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that within value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among the social risk factors they examined and tested.[11] ASPE is continuing to examine this issue and its second report is due to Congress in the fall of 2019. CMS also notes the NQF has concluded a 2-year trial period in which new measures, measures undergoing maintenance review, and measures endorsed with the condition that they enter the trial period were assessed to determine whether risk adjustment for selected social risk factors were appropriate. The final NQF report concluded that "measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship" between social risk factors and measures. The report notes that this discrepancy may be explained in part by the "methods

[11] https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.

used for adjustment and the limited availability of robust data on social risk factors". [12] NQF has extended the socioeconomic status (SES) trial to allow further examination of social risk factors in outcome measures.

CMS discusses the comments it has received encouraging CMS to explore which factors could be used to stratify or risk adjust measures beyond dual eligibility such as age, income, and educational attainment. As a next step, CMS is considering options to increase the transparency of health disparities as shown in quality measures. In the FY 2019 IPPS/LTCH PPS proposed rule, CMS states it is considering implementing two complementary methods. The first method (the hospital-specific disparity method) would calculate differences in outcome rates among patient groups within a hospital while accounting for their clinical risk factors. It would also allow for a comparison of those differences across hospitals. The second approach would assess outcome rates for subgroups of patients, such as dual eligible patients, across hospitals, allowing for a comparison among hospitals on their performance caring for their patients with social risk factors. A CMS contractor will convene a Technical Expert Panel in the spring of 2018 to solicit feedback from stakeholders on approaches to consider for stratification for the Hospital Inpatient Quality Reporting (IQR) Program. CMS also plans to continue to work with ASPE and stakeholders to identify policy solutions.

1. New Measure Removal Factor

CMS uses seven factors for evaluating whether or not a measure should be removed for the HQRP measure set (80 FR 47186). The current removal factors consider whether 1) the measure is "topped out;" 2) performance or improvement on the measure does not result in better patient outcomes; 3) the measure does not align with current clinical guidelines or practice; 4) another more broadly applicable measure is available; 5) another measure that is more proximal in time to desired patient outcome for a particular topic is available; 6) another available measure is more strongly associated with the desired patient outcomes; and 7) collection or public reporting of the measure leads to negative unintended consequences other than patient harm. CMS notes that none of the factors results in automatic removal; these are considerations that are taken into account on a case-by-case basis.

CMS is proposing an eighth factor: the costs associated with a measure outweigh the benefit of its continued use in the program. CMS notes that there are different types of costs associated with measures. These include the direct cost of information collection and submission of quality measures to CMS; the provider and clinician cost associated with complying with quality program requirements; the provider and clinical cost associated with participating in multiple quality programs and tracking similar or duplicative measures across programs; the CMS cost associated with program oversight of the measure; and the provider/clinician cost associated with compliance with other federal or state regulations (if applicable). CMS also notes that beneficiaries may find it confusing to see public reporting on the same measure in different programs. CMS says its goal is to move the program forward in the least burdensome manner possible while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize quality improvement.

[12] The final report is available at: http://www.qualityforum.org/SES_Trial_Period.aspx.

2. Previously Adopted Quality Measures for FY 2018 Payment Determination and Future Years

In the FY 2014 Hospice final rule (78 FR 48258), CMS finalized the HIS as the data collection mechanism for reporting HQRP measures. CMS also finalized that hospice providers are required to provide regular and ongoing electronic submission of the HIS data for each patient admission to hospice on or after July 1, 2014, regardless of payer or patient age.

Table 17 in the proposed rule (reproduced below) provides a summary of measures previously finalized for the FY 2019 annual payment update (APU).

Table 17: Previously Finalized Quality Measures Affecting the FY 2019 Payment Determination and Subsequent Years

NQF Number	Measure Name	Year the Measure was Adopted for Use in the Annual Payment Determination (APU)
1641	Treatment Preferences	FY 2016
1647	Beliefs/Values Addressed (if desired by the patient)	FY 2016
1634	Pain Screening	FY 2016
1637	Pain Assessment	FY 2016
1639	Dyspnea Screening	FY 2016
1638	Dyspnea Treatment	FY 2016
1617	Patients Treated with an Opioid Who Are Given a Bowel Regimen	FY 2016
3225	Hospice and Palliative Care Composite Measure – Comprehensive Assessment at Admission	FY 2019
To Be Determined	Hospice Visits When Death is Imminent	FY 2019

The Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission measure received NQF endorsement in July 2017. Data for the Hospice Visits when Death is Imminent measure pair is being collected using new items added to the HIS V2.00.0, effective April 1, 2017. When at least 4 quarters of reliable data is available for the Hospice Visits when Death is Imminent measure, CMS will submit this measure for NQF endorsement.

In the FY 2015 Hospice final rule, CMS also finalized the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey to support quality measures based on patient and family experiences of care.

3. Form, Manner, and Timing of Quality Data Submission

In the FY 2015 Hospice final rule, CMS finalized its policy requiring hospices complete and submit HIS records for all patient admissions in accordance with the specified reporting requirements (79 FR 50486). Hospices currently have 36 months to modify HIS records. CMS

notes that only data modified before the public reporting "freeze data" are reported on the CMS Hospice Compare Web site.[13]

CMS proposes that beginning January 1, 2019 hospices will have a distinct period of time to review and correct data that is to be publicly reported. Specifically, CMS is proposing the data correction deadline for HIS records would occur on the 15th of the calendar year (CY) month that is approximately 4.5 months after the end of the CY quarter, and hospices would have up until 11:59:59 PST on that date to submit corrections or requests inactivation of their data for the quarter involved. For example, for data reported in CY Q1, the freeze date would be August 15th and for Q2, the freeze date would be November 15th. Any modification to or inactivation of records that occur after the proposed correction deadline would not be reflected on the CMS Hospice Compare Web site. CMS notes this proposed policy aligns HQRP with the policies that exist in other quality reporting programs.

CMS proposes that the first quarterly freeze data for CY 2019 data corrections will be August 15, 2019. For HIS records with target dates prior to January 1, 2019 but still within the target period for public reporting, CMS proposes to provide hospices the opportunity to review their HIS data and submit corrections up to the August 15, 2019 deadline. Table 18 in the proposed rule (reproduced below) summarizes the proposed data correction deadlines.

Table 18: Data Correction Deadlines for Public Reporting Beginning CY 2019

Data Reporting Period*	**Data Correction Deadline for Public Reporting***
Prior to January 1, 2019	August 15, 2019
January 1, 2019 - March 31,2019	August 15, 2019
April 1, 2019 – June 30, 2019	November 15, 2019
July 1, 2019 – September 30, 2019	February 15, 2020
October 1, 2019 – December 31, 2019	May 15, 2020

* This CY time period is intended to inform both CY 2019 data and to serve as an illustration for the review and correction deadlines that are associated with each CY of data reporting quarter.

4. CAHPS® Hospice Survey Participation Requirements for the FY 20123 APU and Subsequent Years.

The CAHPS® Hospice Survey for CMS' HQRP collects data on the experiences of hospice patients and the primary caregivers listed in the hospice record. The survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver about the patient and family experience of care. The CAHPS® Hospice Survey measures received NQF endorsement in 2016 (NQF #2651). Measures include 6 composite measures and 2 global rating measures. These 8 measures are reported on Hospice Compare. Questions about the CAHPS® Hospice Survey should be sent to the CAHPS® Hospice Survey Team at hospiceCAHPSurvey@HCQIS.org or telephone 1-844-472-4621.

Data Sources. CMS previously finalized that to meet the HQRP requirements for FYs 2020 through 2022 APU determinations, hospices would contract with a CMS-approved vendor to

[13] Information about the HIS "freeze data" is on the CMS HQRP web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Key-Dates-for-Providers.html.

collect survey data for eligible patients on a monthly basis and report that data to CMS on the hospice's behalf by the quarterly deadlines established for each data collection period. The list of approved vendors is available at http://www.hospiceCAHPSsurvey.org.en.approved-vendor-list. Hospices are responsible for making sure their survey vendors meet all the data submission deadlines.

CMS proposes to extend the current participation requirements to all future years.

Volume-based Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. In the FY 2017 final rule (82 FR 36671), CMS finalized that hospices with fewer than 50 survey-eligible decedents/caregivers in the specified reporting period are exempted from the CAHPS® Hospice Survey data collection and reporting requirements for the corresponding payment determination (corresponds to the CY data collection period). To qualify for this exemption, hospices have to submit an annual exemption request form. The exception request form is available on the CAHPS® Hospice Survey web site at htpp://www.hospiceCAHPSurvey.org.

The key dates for the volume-based exception for the CAHPS® Hospice Survey are summarized in Table 19 in the proposed rule (reproduced below).

Table 19: Size Exemption Key Dates for FYs 2023. 2024, and 2025

Fiscal Year	Data Collection Year	Reference Year (Count total number of unique patients in this year)	Size Exemption Form Submission Deadline
2023	2021	2020	December 31, 2021
2024	2022	2021	December 31, 2022
2025	2023	2022	December 31, 2023

Newness Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. CMS previously finalized a one-time newness exemption for hospices that meet the criteria (81 FR 52181). CMS proposes to continue the newness exemption for FY 2023 and all future years. Specifically, hospices that are notified about their Medicare CCN after January 1, 2021 are exempted from the FY 2023 APU CAHPS® Hospice Survey requirement due to newness. CMS notes no action is required by the hospice to receive this exemption. The newness exemption is a one-time exemption from the survey. CMS encourages hospices to keep the letter providing them with their CCN.

Requirements for the FYs 2023, 2024 and 2025 APU. To meet participation requirements for a given year APU, Medicare certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from the corresponding FY reporting period. Table 20 in the proposed rule (reproduced below) provides the deadlines for data submission for FYs 2023 through 2025. CMS notes there are no late submissions after the deadline, except for extraordinary circumstances beyond the control of the provider.

Table 20- CAHPS® Hospice Survey Data Submission Dates for the APUs in FYs FY 2023-2025	
Sample Month[1]	**Quarterly Data Submission Deadlines[2]**
FY 2023 APU	
January-March 2021 (Q1)	August 11, 2021
Monthly data collection April-June 2021 (Q2)	November 10, 2021
Monthly data collection July-September 2021 (Q3)	February 9, 2022
Monthly data collection October-December 2021(Q4)	May 11, 2022
FY 2024 APU	
January-March 2022(Q1)	August 10, 2022
Monthly data collection April-June 2022 (Q2)	November 9 2022
Monthly data collection July-September 2022 (Q3)	February 8, 2023
Monthly data collection October-December 2022 (Q4)	May 130 2023
FY 2025 APU	
January-March 2023 (Q1)	August 9, 2023
Monthly data collection April-June 2023 (Q2)	November 8, 2023
Monthly data collection July-September 2023 (Q3)	February 14, 2024
Monthly data collection October-December 2023(Q4)	May 8, 2024

[1]Data collection for each sample month initiates two months following the month of patient death (for example, in April for deaths occurring in January).
[2]Data submission deadlines are the second Wednesday of the submission month, which are August, November, February, and May.

5. Public Display of Quality Measures and Other Hospice Data for the HQRP

The Hospice Compare Website allows consumers, providers, and other stakeholders to search for all Medicare-certified hospices and view their information and quality measures.

Adding Quality Measures to Publicly Available Websites – Procedures to Determine Quality Measure Readiness for Public Reporting. CMS discusses the procedures it uses to determine if quality measures meet the readiness standards for public reporting. CMS assesses the reliability and validity of each quality measure (QM) to determine the scientific acceptability of each measure. CMS evaluates the quality measures using the NQF Measure Evaluation Criteria.[14] CMS also examines the distribution of the hospice-level denominator size for each quality measure to assess whether the denominator is large enough to generate statistically reliable scores necessary for public reporting. CMS provides hospices the opportunity to review their measures through their Certification and Survey Provider Enhanced Reports (CASPER): the Hospice-Level Quality Measure Report and the Patient Stay-Level Quality Measure Report.

CMS proposes to announce any future intent to publicly report a quality measure on Hospice Compare, including timing, through sub-regulatory means. CMS states this will allow public reporting in a more expeditious manner. CMS will also continue to provide updates about public reporting of quality measures through the normal CMS HQRP communications channels.

[14] The NQF Measure Evaluation Criteria are on the NQF web site at http://www.quality.forum.org/Measuring_Performance/Sybmitting_Standards/Measure_Evaluation_Criteria.aspx#scientif.

Quality Measures to be Displayed on Hospice Compare in FY 2019. CMS anticipates public reporting of the HIS-based Hospice Comprehensive Assessment Measure (NQF #3235) on the CMS Hospice Compare website in Fall 2019. CMS states that this measure has high reliability and validity. Based on reportability analysis, CMS determined that this measure is eligible for public reporting with a minimum denominator size of 20 patient stays over a 12-rolling month data selection period. CMS notes that using rolling 4 quarters of data, the majority of hospices have at least 20 patient stays eligible for calculation and public reporting.

CMS is also anticipating public reporting of the HIS-based Hospice Visits when Death in Imminent Measure in FY 2019. Pending the finalization of its proposal to announce future intentions to publicly display hospice quality measures through sub-regulatory channels, CMS states the exact timeline for public reporting of this measure will be announced once necessary analysis and measure specifications are finalized.

Updates to the Public Display of HIS Measures. Based on feedback received about how to publicly display the Comprehensive Assessment at Admission measure, CMS intends to publicly display the composite score instead of the seven individual HIS measures. CMS proposes to still provide information about the seven individual measures but they will only be viewable in an expandable/collapsible format under the composite measure. CMS notes this proposal would only change the display of data on the Hospice Compare but would not change any current HIS data collection procedures. In addition, the component measures would still be reported in CASPER QM reports and HIS provider preview reports.

d. Display of Public Use File Data (PUF) and/or Other Publicly Available CMS Data on Hospice Compare. The Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF is available on the CMS website.[15] The primary data for the Hospice PUF is the CMS Chronic Condition Data Warehouse (CCW), a database with 100 percent of Medicare enrollment and fee-for-service adjudicated claims data.

CMS proposes to post information from the PUF and other publicly available data to the Hospice Compare web site in a consumer-friendly data. CMS may display data from the PUF or present data after additional calculations. CMS provides examples of information it may post such as the percent of days a hospice provided routine home care (RHC) to patients averaged over multiple years and percent of primary diagnosis of patients served by a hospice. CMS notes it displays similar information on other Compare Websites such as Nursing Home Compare.

III. Request for Information on Possible Establishment of CMS Patient Health and Safety Requirements for Hospitals and Other Medicare-Participating Providers and Suppliers for Electronic Transfer of Health Information

CMS discusses the status of adoption of health IT between Medicare and Medicaid participating providers. It says that as of 2015, 96 percent of hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care, yet significant obstacles to electronic exchange of health information remain. It reviews CMS and Office of National

[15] The file is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice.html.

Coordinator (ONC) initiatives and regulatory activities aimed at advancing health information exchange. The January 2018 ONC draft Trusted Exchange Framework and Common Agreement (TEFCA)[16] is highlighted.

CMS is interested in feedback from stakeholders on how it should use the Conditions of Participation (CoPs), Conditions of Coverage (CfCs), and Requirements for Participation (RfPs) for Long-Term Care (LTC) Facilities to advance electronic exchange of health information in support of care transitions between hospitals and community providers. As an example, CMS says it might consider revising the hospital CoPs to require that hospitals electronically transfer medically necessary patient information to the other facility when a patient is transferred. Similarly, they might require that hospitals electronically send discharge information to a patient's community provider when possible, and to provide discharge instructions electronically to patients or a third-party application, if requested.

Relevant provisions of proposed CoP regulations are discussed including the November 3, 2015 proposed rule to implement provisions of the IMPACT Act (80 FR 68126), June 16, 2016 proposed changes to CoPs for hospitals and CAHs (81 FR 39448), and an October 4, 2016 final rule on requirements for LTC facilities (81 FR 68688).

In this rule, CMS requests stakeholder feedback on the following questions:

- If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?
- Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?
- Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?
- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid HER Incentive Programs)?
- Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?

[16] The draft is available at https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement

- Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?
- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?
- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

In addition, CMS discusses the MyHealthEData initiative to promote patient access to their medical records and the Blue Button 2.0 initiative for beneficiary access to Medicare claims information through API technology.

CMS seeks ideas from the public on how best to accomplish the goal of fully interoperable health IT and EHR systems for providers and suppliers and how to advance the MyHealthEData initiative for patients. In particular, it would like to identify fundamental barriers to interoperability and patient access and how they might be reduced through revisions to the CoPs, CfCs, and RfPs for hospitals and other Medicare providers and suppliers. CMS has a particular interest in hearing about issues for providers and suppliers who are ineligible for the Medicare and Medicaid EHR Incentives program, such as long-term care and post-acute care providers, behavioral health providers, clinical laboratories and social service providers.

The usual disclaimers applied to a Request for Information are included.

IV. Collection of Information Requirements

CMS is not proposing any new updates or additional collection of information in this proposed rule in regards to the HIS. The OMB approved the HIS V2.00.0 on April 17, 2017 under control number 0938-1153 for 1 year and the information collection request (ICR) is pending OMB approval for 3 years. For the CAHPS® Hospice Survey, the information collection requirements and burden were approved by OMB through December 31, 2020 under OMB control number 0938-1257.

V. Regulatory Impact Analysis

CMS states that the overall impact of this proposed rule is an estimated net increase in Federal Medicare payments to hospices of $340 million or 1.8 percent, for FY 2019. This increase is simply a result of the hospice payment update percentage of 1.8 percent. The aggregate impact of

the annual update to the wage index is zero percent due to the proposed hospice wage index standardization factors.

Table 22 in the proposed rule (recreated here) shows the detailed estimated hospice impacts by facility type and area of country. Variation from the overall impact is due to distributional effects of the annual update to the wage index. In brief, proprietary (for-profit) hospices (64 percent of all hospices) are expected to have an increase in hospice payments of 1.8 percent compared with payment increases of 1.8 percent, and 2.0 percent for non-profit and government hospices, respectively. The projected overall impact on hospices varies most among regions of country – a direct result of the variation in the annual update to the wage index. Hospices providing services in the urban West South Central and rural New England regions would experience the largest estimated increases in payments of 2.2 percent and 3.3 percent, respectively. Hospices serving patients in rural Mountain region would have the smallest increase (1.4 percent) in FY 2019 payments.

TABLE 22: Projected Impact to Hospices for FY 2019

	Number of Providers	**Updated wage data (%)**	**Proposed Hospice Payment Update (%)**	**FY 2019 Total Change (%)**
(1)	(2)	(3)	(4)	(5)
All Hospices	**4,408**	**0.0%**	**1.8%**	**1.8%**
Urban Hospices	3,523	0.0%	**1.8%**	1.8%
Rural Hospices	885	0.1%	**1.8%**	1.9%
Urban Hospices - New England	124	-0.1%	**1.8%**	1.7%
Urban Hospices - Middle Atlantic	249	0.1%	**1.8%**	1.9%
Urban Hospices - South Atlantic	443	-0.2%	**1.8%**	1.6%
Urban Hospices - East North Central	397	-0.1%	**1.8%**	1.7%
Urban Hospices - East South Central	149	0.0%	**1.8%**	1.8%
Urban Hospices - West North Central	241	0.2%	**1.8%**	2.0%
Urban Hospices - West South Central	691	0.4%	**1.8%**	2.2%
Urban Hospices – Mountain	354	-0.3%	**1.8%**	1.5%
Urban Hospices – Pacific	835	0.2%	**1.8%**	2.0%
Urban Hospices – Outlying	40	0.4%	**1.8%**	2.2%
Rural Hospices - New England	27	1.5%	**1.8%**	3.3%
Rural Hospices - Middle Atlantic	35	0.0%	**1.8%**	1.8%
Rural Hospices - South Atlantic	108	0.0%	**1.8%**	1.8%
Rural Hospices - East North Central	137	0.0%	**1.8%**	1.8%
Rural Hospices - East South Central	111	0.0%	**1.8%**	1.8%

	Number of Providers	Updated wage data (%)	Proposed Hospice Payment Update (%)	FY 2019 Total Change (%)
Rural Hospices - West North Central	167	0.3%	**1.8%**	2.1%
Rural Hospices - West South Central	160	0.2%	**1.8%**	2.0%
Rural Hospices – Mountain	92	-0.4%	**1.8%**	1.4%
Rural Hospices – Pacific	42	0.1%	**1.8%**	1.9%
Rural Hospices – Outlying	6	-0.3%	**1.8%**	1.5%
0 - 3,499 RHC Days (Small)	975	0.3%	**1.8%**	2.1%
3,500-19,999 RHC Days (Medium)	2,036	0.1%	**1.8%**	1.9%
20,000+ RHC Days (Large)	1,397	0.0%	**1.8%**	1.8%
Non-Profit Ownership	1,026	0.0%	**1.8%**	1.8%
For Profit Ownership	2,830	0.0%	**1.8%**	1.8%
Govt Ownership	141	0.2%	**1.8%**	2.0%
Other Ownership	411	0.0%	**1.8%**	1.8%
Freestanding Facility Type	3,608	0.0%	**1.8%**	1.8%
HHA/ Facility-Based Facility Type	800	-0.1%	**1.8%**	1.7%

Source: FY 2017 hospice claims data from the Chronic Condition Data Warehouse (CCW) Research Identifiable File (RIF) as of February 2, 2018.

REGION KEY: New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; **Middle Atlantic=**Pennsylvania, New Jersey, New York; **South Atlantic=**Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; **East North Central=**Illinois, Indiana, Michigan, Ohio, Wisconsin; **East South Central=**Alabama, Kentucky, Mississippi, Tennessee; **West North Central=**Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; **West South Central=**Arkansas, Louisiana, Oklahoma, Texas; **Mountain=**Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; **Pacific=**Alaska, California, Hawaii, Oregon, Washington; **Outlying=**Guam, Puerto Rico, Virgin Islands

CMS considers the proposed rule economically significant and a major rule under the Congressional Review Act; it has been reviewed by OMB. CMS states that the Secretary has determined that the proposed rule will not create a significant economic impact on a substantial number of small entities or on the operation of a substantial number of small hospitals. It is also not anticipated to have an effect on State, local, or tribal governments, in the aggregate, or on the private sector of $150 million or more, the current threshold under the Unfunded Mandates Reform Act.